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Processing the Hidden Disability of Disabilities with EMDR

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Abstract: Eye Movement Desensitization and Reprocessing (EMDR), a standardized, eight-phased psychotherapeutic modality developed by Francine Shapiro, is well researched for its utility in assisting individuals in processing traumatic events. The author's personal and professional experiences as an individual with a life-long, physical disability, a mid-level psychiatric practitioner, and an EMDR-certified clinician have allowed for lived and witnessed understanding of adverse events in the form of hidden disability secondary to diagnosed mental and physical disabilities. EMDR has been utilized as a successful treatment modality for hidden disability by the author, as outlined in a case overview.

Keywords: EMDR; Disability; Trauma

Knowledge Focus: Research/Theory Focus

Topic: Health & Wellbeing

Introduction

As an individual with a life-long, physical disability and as a mental health professional treating individuals with mental and physical disabilities, I have parallel experience bearing witness to my own adversities and the adversities of others. My role as an adult psychiatric nurse practitioner in private practice has allowed me the privilege of working with individuals with mental disabilities, physical disabilities, intellectual disabilities, and trauma histories. In order to assist my clients in processing their adverse experiences and traumas, I sought out training and certification in Eye Movement Desensitization Reprocessing (EMDR) which was developed by Francine Shapiro, and have since utilized EMDR to assist my clients in processing a variety of traumatic events.

Explanation of Trauma

While many individuals commonly think of trauma as a life-threatening or catastrophic event, such as fighting in combat or a near-death experience, trauma can simply be defined as a "psychological, emotional response to an event or an experience that is deeply distressing or disturbing" (CTAMD, 2017, para. 1). This broad definition allows for the classification of traumas as 'little t' or 'big T' events (EMDR Institute, 2019). 'Little t' traumas may include someone's best friend moving away in 5th grade, being rejected by peers in PE class due to having a disability, and facing other injuries and threats to a person's general well being. 'Big T'

traumas may include being victimized by abuse, crime, or natural disaster and facing injury or threat to a person's life and physical safety (or the life and safety of others). Individuals with disabilities are subjected to repeated experiences of trauma in childhood and adulthood and, as such, carry the pain and stigma of hidden disability underlying and secondary to diagnosed disability. In this practitioner's personal and professional experience, hidden disability can scar deeply within the psyche and cry out for acknowledgement, understanding, and healing.

Trauma is held in the brain, mind, and body by the autonomic nervous system, and by the 'relay system' in the brain that transmits signals to the hippocampus, amygdala, and prefrontal cortex in direct response to triggering events. Traumatized individuals often hold unprocessed memories that 'tell the story' about distressing and disturbing events and continue to experience highly charged physical and emotional reactions many years after the original event. These individuals may later seek out assistance from health care providers and clinicians, asking for medications to alleviate symptoms of depression or anxiety and 'telling their story' over and over in counseling sessions (or to sympathetic individuals who will listen). Why do medications and traditional talk therapy often fail to provide the desired effect? Quite simply, they fail because traumatic memories and experiences are stored in the 'gut,' become entwined with firmly-held negative cognitions and beliefs, and require a brain-mind-body approach to truly allow for processing of trauma.

Explanation of EMDR

Eye Movement Desensitization and Reprocessing (EMDR) allows the individual to maintain dual attention on a past traumatic event while in the present and utilizes bilateral stimulation (consisting of left and right visual, tactile, or auditory input) to allow the brain, mind, and body to synchronize, and then recall and re-experience a past traumatic event in the context of a safe, therapeutic environment. By maintaining dual attention, the individual is finally able to process what was previously too distressing and too disturbing, thus resulting in unprocessed or raw and re-lived trauma. EMDR consists of eight standardized phases, including: history and treatment planning, preparation, assessment (processing and reprocessing), desensitization, installation, body scan, closure, and re-evaluation of outcomes of treatment.

Exposure to and Application of EMDR

I was originally trained in EMDR in 2015 and became certified in 2017. My initial exposure to EMDR included processing a childhood medical trauma during a training weekend, and I was shocked to discover that I was still adversely affected by this medical trauma so many years later (as my mind had tucked away the emotional intensity of this experience, hidden and unhealed). In actuality, I was originally highly skeptical about the true benefit of EMDR, as it was unlike other psychotherapeutic treatment modality that I had encountered (such as cognitive behavior therapy). Nevertheless, in spite of my skepticism, EMDR was highly effective in resolving my psychological and physiological feelings of distress at this very first training

weekend, thus piquing my curiosity and desire to learn more about its clinical application and to build on my ability to successfully perform EMDR in session. I have since utilized EMDR with numerous clients, including individuals with mental and physical disabilities, and have listened to them ‘tell their stories’ about the isolation, loneliness, invalidation, shame, worthlessness, fear, and anger experienced and re-experienced as hidden disabilities secondary to their diagnosed disability.

Case Presentation

One such client is a middle-aged male with cerebral palsy who was teased and shamed by his peers, and who suffered repeated invalidating and traumatizing events during his childhood. He sought help because of his present-day issues, including low self-esteem, interpersonal difficulties, and nightmares, and came to realize that he had been carrying a legacy of psychological trauma just as heavy as the weight of his physical disability itself for many, many years. He responded equally as well as I did to EMDR and was and is grateful to not carry the legacy of psychological trauma into his present and future. He likened the power and efficacy of EMDR in allowing for the processing of trauma to having ‘emotional surgery.’ The opportunity to achieve psychological healing and recovery following each ‘emotional surgery,’ or EMDR session, has been truly transformative for this individual client.

One early EMDR session focused on the target image of his feet being kicked out from under him while his peers laughed at him. This was associated with the negative cognition of "I'm not as valuable or worthy as others,” with the desired positive cognition that "I still have my humanity - I don't have to be jaded.” His Subjective Units of Disturbance Scale (SUDS) was 7–8 out of 10 (with 10 being severe), and his Validity of Cognition scale (VOC) was 1 out of 7 (not true). He reported feeling emotions of being alone, helpless, unprotected, and vulnerable and body sensations of discomfort in his “gut” and in his legs. Following a single EMDR session, his SUDS was 0 out of 10, and his VOC was 7 out of 7 (very true), which is indicative of a successful treatment outcome. Nearly two years later, he has continued to report that this targeted trauma remains at a SUDS of 0 out of 10 following EMDR and that his nightmares that plagued him for decades stopped completely following EMDR.

Conclusion

EMDR is offered by mental health providers who have been trained under established guidelines through the EMDR International Association (EMDRIA). By sharing an overview of EMDR and an individual case, this practitioner aims to foster a greater appreciation for utilization of EMDR as a treatment modality for individuals with trauma histories, including those with mental and physical disabilities who are burdened by hidden disability. For this author and the aforementioned client, the ability to successfully undergo ‘emotional surgery,’ in the form of EMDR, for hidden disability and trauma is equally as transformative and life-changing as any medical and surgical treatment designed to target physical disability. This practitioner

carries the hope that clients, under the guidance and support of trained clinicians, will evaluate and explore the potential benefit of using EMDR as a form of psychotherapeutic ‘emotional surgery’ in their journey of healing from adverse and traumatizing events.

Author

Sandra Carrier is an adult psychiatric nurse practitioner. Born in Yokosuka, Japan at 3 months premature, she weighed 2 lb, 4 oz and was later diagnosed with cerebral palsy. She walked at age 4 following the first of multiple corrective surgeries, and attended a school for the ‘handicapped’ in Hawaii (before mainstreaming). Even at that age, she wanted to be a doctor and have worked in allied health care, becoming a nurse and nurse practitioner. Carrier treats a wide variety of individuals, including and not limited to individuals with physical and developmental disabilities.

Image Description: Photo of Sandra Carrier

Author Note

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